

 **The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit wpshealth.com or call 1-800-332-6451. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> /or call 1-800-332-6451 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | For preferred providers : \$4,500.00 / Covered Person or \$9,000.00 / Family; For non-preferred providers : \$9,000.00 / Covered Person or \$18,000.00 / Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible? | Yes. Preventive care services, office visits and prescription drugs purchased, other than specialty drugs , from a pharmacy are covered before you meet your deductible . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | Yes. \$500.00 / Covered Person for specialty drugs . There are no other specific deductibles . | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | For preferred providers : \$7,900.00 / Covered Person or \$15,800.00 / Family; For non-preferred providers : \$19,000.00 / Covered Person or \$38,000.00 / Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit? | Premiums , balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider? | Yes. See https://connect.wpsic.com/Gateway/commercialGateway/unauth/fadHome.do or call 1-800-332-6451 for a list of network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral . |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|--|--|--|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$45.00 copayment / office visit and 20% coinsurance for other outpatient services; deductible does not apply to the office visit charge | 50% coinsurance | \$0 copayment / telehealth visit charge with our approved telehealth provider \$10.00 copayment / office visit charge for a preferred convenient care clinic visit \$45.00 copayment / visit for preferred chiropractor |
| | Specialist visit | \$90.00 copayment / office visit and 20% coinsurance for other outpatient services; deductible does not apply to the office visit charge | 50% coinsurance | None |
| | Preventive care/screening/immunization | No charge | 50% coinsurance | You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive . Then check what your plan will pay for. You also have no charge for immunizations provided by a non-preferred provider . |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance | 50% coinsurance | Certain genetic tests and high-technology imaging may require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | |
| If you need drugs to treat your illness or condition | Generic drugs | \$25.00 copayment / prescription (retail) & \$62.50 copayment / prescription (home delivery) | \$25.00 copayment / prescription (retail) & \$62.50 copayment / prescription (home delivery) | Preferred generic drugs are no charge. The deductible does not apply to generic and brand name drugs which are not specialty drugs . |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|--|---|--|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| More information about prescription drug coverage is available at https://wpshealth.com/resources/files/32772-wps-ind-small-group-drug-formulary.pdf | Preferred brand drugs | \$60.00 copayment / prescription (retail) & \$150.00 copayment / prescription (home delivery) | \$60.00 copayment / prescription (retail) & \$150.00 copayment / prescription (home delivery) | Covers up to a 30-day supply retail/90-day supply home delivery. If brand dispensed when generic available, you are responsible for the dollar amount difference between brand and generic. Drugs provided by an entity other than a pharmacy require prior authorization. Benefits may not be payable if you do not obtain prior authorization. Specialty drugs are subject to a separate deductible amount and are always limited to a 30-day supply. Specialty drugs require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| | Non-preferred brand drugs | \$100.00 copayment / prescription (retail) & \$250.00 copayment / prescription (home delivery) | \$100.00 copayment / prescription (retail) & \$250.00 copayment / prescription (home delivery) | |
| | Specialty drugs | 40% coinsurance / prescription (retail & home delivery) | 40% coinsurance / prescription (retail & home delivery) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | None |
| If you need immediate medical attention | Emergency room care | \$500.00 copayment / emergency room charge and 20% coinsurance for other emergency room services; deductible does not apply to the emergency room charge | \$500.00 copayment / emergency room charge and 0% coinsurance for other emergency room services; deductible does not apply to the emergency room charge | Urgent care professional charges may be subject to the \$90.00 specialist office visit copayment depending on the specialty of the physician providing treatment. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | |
| | Urgent care | \$45.00 copayment / urgent office visit and 20% coinsurance for other urgent care services; deductible does not apply | \$45.00 copayment / urgent office visit and 20% coinsurance for other urgent care services; deductible does | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|---|--|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| | | to the urgent office visit charge | not apply to the urgent office visit charge | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$45.00 copayment / therapy office visit and 20% coinsurance for other outpatient services; deductible does not apply to the therapy office visit charge | 50% coinsurance | Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| | Inpatient services | 20% coinsurance | 50% coinsurance | |
| If you are pregnant | Office visits | \$45.00 copayment / office visit and 20% coinsurance for other outpatient services; deductible does not apply to the office visit charge | 50% coinsurance | Cost sharing does not apply to certain preventive services . Depending on the type of services, deductible and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| | Childbirth/delivery professional services | 20% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 50% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 20% coinsurance | 50% coinsurance | Coverage is limited to 60 visits/year |
| | Rehabilitation services | \$45.00 copayment / therapy office visit and 20% coinsurance for other outpatient services; | 50% coinsurance | Rehabilitation services: Coverage is limited to 20 visits/year for physical therapy; 20 visits/year for |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|---|--|
| | | Preferred Provider (You will pay the least) | Non-Preferred Provider (You will pay the most) | |
| | | deductible does not apply to the therapy office visit charge | | occupational therapy; and 20 visits/year for speech therapy. Habilitation services: |
| | Habilitation services | \$45.00 copayment / therapy office visit and 20% coinsurance for other outpatient services; deductible does not apply to the therapy office visit charge | 50% coinsurance | Coverage is limited to 20 visits/year for physical therapy; 20 visits/year for occupational therapy; and 20 visits/year for speech therapy. |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | Coverage is limited to 30 days per confinement in a skilled nursing facility. Non-emergent admissions require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Coverage is limited to a single purchase of a type of durable medical equipment every three years. Prior authorization required for: <ul style="list-style-type: none"> • All CPAP purchases and rentals • Purchases over \$1,000 • All other rentals as stated on our website Benefits may not be payable if you do not obtain prior authorization. |
| | Hospice services | 20% coinsurance | 50% coinsurance | Hospice services require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | Coverage limited to one exam/year. |
| | Children's glasses | No charge | Not covered | Coverage limited to one pair of glasses/year. |
| | Children's dental check-up | Not covered | Not covered | No coverage for dental check-ups. |

Excluded Services & Other Covered Services:

| | | |
|---|---|--|
| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | |
| <ul style="list-style-type: none">• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)• Acupuncture• Bariatric Surgery• Cosmetic Surgery | <ul style="list-style-type: none">• Dental Care• Infertility Treatment• Long Term Care• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Private Duty Nursing• Routine eye care (Adult)• Routine Foot Care• Weight Loss Programs |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
| <ul style="list-style-type: none">• Chiropractic Care | <ul style="list-style-type: none">• Hearing Aids | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for the U.S. Department of Labor, Employee Benefits Security Administration 1-866-444-3272 or www.dol.gov/ebsa, or the Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: WPS at 1-800-332-6451. You may also contact your state insurance department at 1-800-236-8517 or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|------------|
| ■ The plan's overall deductible | \$4,500.00 |
| ■ Specialist copayment | \$90.00 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

| | |
|---------------------------|--------------------|
| Total Example Cost | \$12,800.00 |
|---------------------------|--------------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|-------------------|
| Deductibles | \$4,500.00 |
| Copayments | \$100.00 |
| Coinsurance | \$1,000.00 |
| What isn't covered | |
| Limits or exclusions | \$10.00 |
| The total Peg would pay is | \$5,610.00 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|------------|
| ■ The plan's overall deductible | \$4,500.00 |
| ■ Specialist copayment | \$90.00 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

| | |
|---------------------------|-------------------|
| Total Example Cost | \$7,400.00 |
|---------------------------|-------------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|-------------------|
| Deductibles | \$100.00 |
| Copayments | \$2,860.00 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$2,960.00 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|------------|
| ■ The plan's overall deductible | \$4,500.00 |
| ■ Specialist copayment | \$90.00 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 20% |

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

| | |
|---------------------------|-------------------|
| Total Example Cost | \$1,900.00 |
|---------------------------|-------------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|-------------------|
| Deductibles | \$1,300.00 |
| Copayments | \$600.00 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,900.00 |